MEDICAL PATHOLOGY AND THERAPEUTICS AND PRACTICAL MEDICINE.

15. *Hypertrophy of the Brain in Children.*—Mr. Cathcart Lees relates, in the *Dublin Journal of Medical Science* for September last, three cases of this occurring in his own practice, and presents some interesting remarks as to the diagnosis of that condition.

We subjoin the cases with his general conclusions.

"Case I.—John Harding, aged two years, a full, heavy-looking child, was admitted into the hospital in May, 1842, for pertussis; his mother states that he has always been healthy, but very *heavy* and *drowsy*, not playful like her other children; his appetite has always been *great*. The head is rather larger than it ought to be in proportion to his age, particularly across the parietal protuberances, which form considerable projections; the frontal bone also projects over the root of the nose; fontanelles perfectly ossified; his eyes are large, prominent, and widely set; the intelligence is perfect, but he appears to be very *apathetic*, and does not mind any object attentively but his food, for which he is very greedy; he is easily made to cry; there was no fever on him, but the paroxysms of the cough were very violent, and frequently succeeded by convulsions, which were general, and in one of which he died on the sixth day of his disease.

"On removing the calvarium, the dura mater appeared to be tense, and on dividing it, the cerebrum appeared swollen, and protruded through the membranes; the convolutions appeared to be flattened as if compressed; the vessels of the pia mater were injected with very red blood; the substance of the brain was much congested, but of a firm consistence and very large; there was no serous effusion into the ventricles; there was a slight vascularity of bronchial mucous membrane; the bronchial glands were not enlarged; the larynx was perfectly healthy; there were a very few dark, firm spots, like the dots in pulmonary apoplexy, scattered through the lungs, and quite isolated; all the nerves were carefully dissected, and presented nothing abnormal.

"Case II.—Ann Murphy, aged three, a very delicate looking child, with the head large in proportion to the body, which is emaciated, particularly the lower extremities; the abdomen is tumid; there is considerable projection of the frontal bone, as also of the posterior angles of both parietal bones; the eyes are heavy, and widely set, so as to give the child the face of one with chronic hydrocephalus; the fontanelles are quite closed and firm, but cartilaginous; she is very cross and greedy, crying whenever she sees food, till she gets it, when she falls asleep over it; in fact she spends her time in crying, eating, and sleeping. Her intellect is obtuse, but appears to be perfect; the pulse was generally regular, and her pupils natural. She had been left at the gate of the hospital, so we did not know her previous history, but she remained some months under my observation previous to her death, which took place gradually from chronic diarrhœa, without convulsions.

"The brain weighed two pounds three ounces; the dura mater was firmly adherent to the cranium; the brain was large, the dura mater being rather tense over it; the substance of the brain was firmer than is natural in a child of that age, and also of a paler appearance; there was not any fluid in the ventricles nor at the base of the brain; in fact, it appeared to be nearly void of either blood or serum; there were not any tubercles in either the lungs or abdomen.*

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* "It is very difficult to ascertain with any degree of accuracy, the average weight of the healthy brain at different periods of life, and still more, the weight of it in various diseases, as it must be always open to a source of fallacy, resulting from other causes, as the amount of congestion, fluid, and the results of disease; thus, Dr. Sims has given a table containing the weight of 253 brains in different diseases, and then states that the weight of the brain cannot be fixed by any means, however accurate, which is further proved by several cases given by him, in which the brain was found unusually large and heavy from various causes, but which did not constitute hypertrophy.

"Case III.—Mary L., aged seven, light brown hair, delicate skin, appears as if she is always dropping asleep; her pupils are natural; pulse regular; her functions are well performed; her temper is very bad; she will not learn her lessons, but this appears to depend more upon indolence than stupidity; her appetite is very great; her head is not too large in proportion to her body, but there is considerable projection across the parietal protuberances; she complains frequently of headache, and sometimes vomits in the morning. I was consulted on July 10, 1842, for a strumous swelling in the neck of this child, and was so struck by her appearance, that I inquired particularly into her history.

"I have placed these cases in apposition, in order that we may compare them with regard to their early symptoms, as I think they are chiefly valuable from their accurate previous history, for in none of the cases which have been hitherto published, has there been any stress laid on this point, which, however, is of paramount importance. In the cases related by Andral, headache, convulsions, and epilepsy, appear to have occurred, but they only came under his observation in the second, or acute stage of this state, when the brain was suffering from compression, as in his cases the dimensions of the cranium were not larger than natural, which must cause a great difference in the symptoms. Thus idiocy, which depends so frequently on atrophy of the brain, may be caused by hypertrophy, if there be much compression, whereas, if the cranium be developed in the same ratio with the brain, there are often no symptoms produced, or but slight ones, as in a case related by M. Scoutteten,* where a child of five years old was affected with hypertrophy of the brain (with enlargement of the skull) to such a degree, that the head became as large as that of an adult, particularly prominent at the occipital protuberances; the cerebral functions were undisturbed, and the only phenomena which the child presented during life were the frequent fallings occasioned by the weight of the head, which was carried forward whenever the child wished to run, and a great tendency to sleep when he remained quiet. He died of acute enteritis, and the brain exhibited a great developement of all its parts, with only a small quantity of reddish serum in the ventricles.

"Let us now classify the symptoms which the above cases presented, and see how far they may assist us in establishing a diagnosis.

"First, with regard to intelligence.

"There was a peculiar *obtuseness of intellect*, characterised chiefly by *apathy* to external objects, and a great tendency to drowsiness. There also was evinced a *peculiar irritability* of temper.

"Andral states, that in adults, headache, with severe exacerbations, is a prominent symptom; this also occurred in the last case detailed by me. He also mentions weakness of the limbs, often ending in paralysis, convulsion, epilepsy; but these symptoms belong to the second period of this state, when it has passed into the acute stage; but as it is an essential feature of every hypertrophy to develope itself slowly, I have only had an opportunity of studying this state in the first or chronic period, as the two first children died of other diseases before they had reached the second period, which most probably would occur about the second dentition; thus in observation 4th of Andral, the boy became epileptic at the age of seven years, and died comatose, after a fit, at nine years old.

"The *appetite was very great* in all the cases which I have noted, and there existed the *peculiar projection of the parietal protuberances*, on which Dr. Munchmeyer particularly insists, and which, I think, may prove a valuable guide in aiding to discriminate this state from chronic hydrocephalus, with which disease it is most frequently confounded. Thus, in the first case related by Dr. Sims, the mother of the child informed him that they had wished to tap the head at one of the hospitals. And Dr. Hennis Green,† in an excellent article on this subject, states that he recently had seen a child who had been condemned to death by a medical man, as having water on the brain, but which was a case of simple hypertrophy, and which did not interfere with the health of the child. The diagnostic sign which he gives, is the sensation of firmness communicated to the finger, on pressure being made over the fontanelles, in cases of hypertrophy, as contrasted with the fluctuating feel in cases of chronic hydrocephalus; but this could not apply in cases of very young children, or in extreme cases.

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* Archives Generales, vol. vii.

† Provincial Medical and Surgical Journal.

"The prognosis in children is not necessarily unfavourable, for as it is rather an error of development than an actual disease, there is a natural tendency to return to the normal state; the chief danger, in fact, arising from the occurrence of other diseases, as those attendant on dentition, the exanthemata."

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16. *Empyema terminating favourably by spontaneous opening.*—Samuel Shortridge, Esq. records in the *Edinb. Medical and Surgical Journal* for October last, an exceedingly interesting case, illustrative of the manner which nature often adopts for effecting a cure in cases of pleurisy terminating in empyema.

The subject of this case was a man of a stout, robust appearance, who presented the usual symptoms of acute inflammatory fever, accompanied with cough, dyspnœa, and a fixed pain near to the inferior border of the left scapula, extending across the posterior surface of the chest.

On the 3d of October, 1838, while engaged in raising a heavy piece of timber, "he felt something give a crack" in the foregoing position, which, however, did not prevent him continuing his employment during the entire day; but on the following day, while rowing a boat, he became chilly and squeamish, and was forced to bed, when the above symptoms made their appearance.

Mr. S. saw him on the 5th of October, and took blood to syncope, and prescribed an antimonial saline mixture, some powders containing calomel and antimonial powder, and applied a sinapism to the painful part.

On the following day, there being no improvement, the blood-letting was repeated, a large blister was applied, and the medicine continued. The sputa, which now became more copious, from its rusty character, and the ordinary stethoscopic indications, enabled me to consider the inflammatory action to have extended to the substance of the lung. The usual antiphlogistic measures were continued; blisters repeated from time to time; and in the course of a few days, the acute febrile symptoms subsided; but there still remained the fixed pain near the scapula, frequent cough, copious expectoration, and a total inability to lie upon the right side, any attempt at which greatly aggravated the cough and dyspnœa. Very little benefit was derived from the treatment adopted; colliquative perspirations were superadded, to ameliorate which, mineral acid and quinine were had recourse to.

Towards the end of December, debility and emaciation had advanced progressively, and a fulness was observed over the left side of the chest, although no difference in its capacity was found upon measurement; percussion on the part elicited a dull sound; and the respiratory murmur was very faint, although audible over the subclavian region; and a few days after, a soft tumour appeared on the fifth intercostal space, an inch below, and to the outside of the left nipple.

The next day Mr. S. found that the surface of the tumour had ulcerated, and the patient lay bathed in purulent matter, the bed and clothes being fully saturated with it. The purulent matter continued to flow daily from the aperture, and and some came afterwards by the mouth. The patient was afterwards kept comfortable by evacuating the purulent matter night and morning to the extent of a pint, which was facilitated by turning him to the left side, and requesting a full inspiration and a cough to be made, when a soft pledget with a quantity of tow and a bandage was applied.

The cough and dyspnœa were now greatly relieved; a generous diet, with porter, together with the acid and quinine, were prescribed, under which he gradually regained so much strength as allowed him to go out of doors by March, 1839, and henceforward he continued still so weakly as only to be able to walk a very short distance, while the purulent matter was continued to be evacuated night and morning, in nearly the same quantities as at first, by removing the bandages, &c. until three weeks ago, when blood appeared instead of purulent matter, and the wound thereafter closed, leaving a flattened, thimble-like cavity, into which the point of the finger could be introduced; and he has since progressed in strength.

Upon examination, the movements of both sides of the chest are equable, and the respiratory murmur natural, as also the sound elicited by percussion.

The successful result of this case may, perhaps, be regarded as a support to the practice generally adopted, of gradually evacuating such collections, as it is very probable that only as much purulent matter flowed in the first instance as reduced it to the level of the aperture.

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17. *Cirrhosis of the Lung.*—Dr. Stokes exhibited to the Pathological Society of Dublin a specimen of that disease of the lung, first described by Dr. Corrigan, under the title of cirrhosis of the lung. Its general characters are, a tendency to consolidation or contraction of the pulmonic tissue, with dilatation of the bronchial tubes. Dr. Stokes' patient had been labouring for months under cough, with dyspnœa and hectic fever, and died two days after her admission into the hospital. The physical signs were dulness of sound on percussion over the upper part of both lungs, but no decided or unequivocal signs of cavities. The appearance of the lungs on dissection was very characteristic; the left, which was the more diseased, was greatly diminished in size, and very irregular on its surface, so that when the hand was passed over it numerous small bodies could be felt, conveying to the fingers the impression of tubercles existing on the surface of the organ; this was produced by the presence of air vesicles. On making a longitudinal section of the trachea and primary divisions of the bronchi, the right bronchus, immediately after it branched off from the trachea, became greatly dilated, so as to exceed the latter in diameter, while the left bronchus was evidently contracted and reduced below its ordinary calibre, but dilated again a little further down.

At a subsequent meeting, Dr. Greene exhibited another specimen of pulmonary cirrhosis, with dilated bronchial tubes, closely resembling phthisical cavities, taken from a woman who had long suffered from intractable cough, and who was affected with a train of symptoms closely resembling phthisis. The physical signs were, cavernous respiration and distinct pectoriloquy in the right infra-clavicular space; the latter sign was also found at the inferior angle of the scapula, and in the right axilla; distinct gargouillement, with bronchial respiration could be heard in various parts of the chest. The left lung presented the signs of bronchitis. The lung, on examination after death, was found to be diminished in size and indurated; the cavities formed by the dilatation of the tubes were of considerable size, and did not contain purulent matter; they were largest near the surface of the lung, and towards its upper part. Their cartilaginous structure could be distinctly traced. There was not any sign of tubercular deposition in either lung. The pleura was greatly thickened, and the diaphragm was adherent to the liver.

Lænnec attributed this complaint to constant cough, and accumulation of mucus in the bronchial tubes. His opinion is, however, liable to objection, and his account of the causes to which the dilatation is owing is not sufficient to explain all the phenomena. According to Dr. Corrigan, the primary seat of the disease is in the web of cellular tissue which constitutes the matrix of the lung, which has a tendency to contract, so as to produce, when the disease is advanced, a very considerable obliteration of the air-cells. He thinks the diminution of the lung the first step in the disease, of which the dilatation of the bronchi is a consequence.—*Prov. Med. Journ.* Aug. 13, 1842, from *Dublin Medical Journ.* May 1842.

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18. *Microscopical characters of the sputa in Phthisical Patients.*—M. Sandras read before the Academy of Medicine of Paris, August 30th, a memoir on this subject. He selected from the Hotel-Dieu, patients in whom phthisis was well marked; after having collected their sputa in a small tube, he submitted them to a microscope of 300 diameters, and he believes that his experiments will confirm the already existing opinion, that the expectoration of consumptive people

is quite different from that given off by the lungs in other diseases, and that they show further, that this mode of examination will materially assist the diagnosis of this disease, formed by the stethoscope. He found that the expectoration consisted of numerous round globules, separated from each other, of a greyish white colour, and similar in size and form to the globules of pus, but differing from them in this respect, that the latter are circumscribed, while the former are surrounded by a kind of rough layer, which it is impossible to remove by washing. They are also opaque in the centre, and become gradually clearer as we approach their border. The above data were drawn from 49 patients; but he observes at the same time, that the sputa of all phthisical subjects do not present a similar appearance,—a circumstance which can be easily accounted for, when we consider that invalids are in general affected at the same time with bronchitis. M. Sandras was unable to discover the globules above described, in tuberculous abscesses in other parts of the body. On examining the expectoration from simple catarrh, it was found to be apparently similar in appearance, having small corpuscles, but no globules; these were not isolated from each other, were not all of a like size, disappeared or only appeared in an indistinct manner under the microscope, and their surface was frequently striated. Notwithstanding these striking differences, cases are occasionally met with, in which it is very difficult to decide whether the disease is phthisis or bronchitis. M. S. does not think that the pus comes from the tubercular matter itself, but from the secretion in the centre of which the tubercle is placed; nevertheless, the signs afforded by it are not of less importance in the diagnosis of the disease.—*L. & E. Monthly J. Med. Sc.* Oct. 1842.

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19. *Treatment of the Hemorrhagic Diathesis.—The London and Edinburgh Monthly Journal of Medical Science* for July last contains an exceedingly interesting paper on this subject, read before the Medico-Chirurgical Society of Edinburgh, by James Miller, the successor of Sir Charles Bell, in the Surgical chair of the University of Edinburgh.

To constitute the hemorrhagic diathesis, we have not only, Mr. Miller observes, the blood flowing through dilated and non-contractile tubes, but sent thither in greater volume than in ordinary and healthy circumstances, thinner and more fluent than in health, and little if at all able to arrest its own course by assuming the solid form. In addition, the capillary tunics are not only thin, but weak, and easily lacerable; a slight bruise produces serious ecchymosis; coughing may induce hæmoptysis; a sneeze brings on epistaxis; diarrhœa occasions copious evacuations of blood by the rectum; and extravasations are not unlikely to follow but slight causes within internal cavities. The whole circulating system, besides, is usually in an irritable and excited condition; the pulse being considerably above the healthy standard, and the heart acting with unusual force and sharpness. Not unfrequently, a febrile condition at the same time exists; and when it does exist, it increases the intensity of the diathesis.

In the treatment of the hemorrhagic diathesis, Mr. M. directs attention to the following points:—1. *Energetic treatment at the outset*, for then only have we the blood favourable for coagulation, and the parts tolerant of pressure. 2. *The propriety of internal remedies*—astringents, sedatives, nauseants, and hydragogues—to obviate, if possible, the morbid condition of the blood; and administered either by the mouth or anus, according to circumstances. 3. *Abandonment of escharotics*—especially of the actual cautery, being at the best only occasionally and temporarily beneficial, and ultimately highly pernicious. 4. *Pressure*, preceded by a styptic, early, accurately, uniformly, and yet moderately applied, the best local means of treatment. 5. *Irritants and cupping*, at some distance from the bleeding point, not unlikely to prove beneficial; the former by creating an inflammation in a comparatively unimportant part, and thereby increasing the amount of fibrin in the general mass of blood; the latter by averting the sanguineous determination to the source of hemorrhage. 6. *Careful avoidance of simply febrile accession*, which would have the effect of exciting the circulation, at the same time diminishing still further the amount of fibrin. 7. *Patient persistence* in the foregoing system, without abrupt or frequent change of remedies. 8. In protracted cases, *nutritious, yet non-stimulant diet.* 9. Failing ordinary means, *transfusion* is to be attempted. 10. The question of *prophylaxis*, not irrational; the tendency being once known, its removal ought at least to be attempted.

20. *Very simple mode of arresting Epistaxis.*—M. Negrier, of Angers, states that the following simple plan almost invariably succeeds in arresting bleeding from the nose:—The child is made to stand erect, with the head elevated. The nostril from which the blood flows is compressed by means of the fingers, and the corresponding arm is directed to be raised perpendicularly, and be retained in that position for about two minutes. The hemorrhage in general was arrested in ten seconds from the moment of raising the arm. Dr. Negrier has met with eleven cases of epistaxis, five of which he details, which were cured by this simple means; and he states, that, whether the hemorrhagy was due to a general plethora, or to a temporary congestion of blood in the head, the sudden elevation of the arm corresponding to the nostril from which the blood flowed almost always suspended the bleeding. Two or three times only he has seen the epistaxis return; but it always ceased on the elevation of the arm. It never, however, returned if the person had lost six to nine ounces of blood before the treatment was had recourse to.

One case is related where a bleeding, resulting from a slight incision of the skin of the upper lip, was arrested by the same simple means. This case was the more remarkable, as the bleeding would not stop, though the wound was covered by court-plaster, and freely cauterized with the solid nitrate of silver. On raising the two arms perpendicularly, the bleeding was arrested on the instant, but restored as soon as they were lowered; but on maintaining them in the perpendicular position for about a couple of minutes, the bleeding was definitively arrested.—*Ed. Med. and Surg. Journ.*, October, 1842, from *Archives Generales*, June, 1842.

21. *Prevention of sore nipples.*—Mr. Marcus recommends as a means of preventing sore nipples, washing these parts and also a great portion of the mamma, three times a day, commencing from the sixth month of pregnancy, with tar water.—*Journ. des Connais. Méd. Prat.*, Feb. 1842.

22. *Deafness cured by the endermic use of Morphia.*—Dr. Hoebeke relates in the *Archives de Med. Belge*, the following case of deafness, the cure of which he ascribes to the endermic use of morphia. A lady had become so deaf after an attack of fever that she could not distinguish a word, unless it was bawled into her ear by applying the mouth close to it. But along with the deafness there was always an incessant noise in the ears—at one time like the hissing of boiling water, at other times like the roaring of a hundred voices together—which was often so distressing as to cause headache and confusion of ideas:—these feelings were always worse when the head was on the pillow. There was a quantity of wax in the ears; but no relief was obtained when it was removed. Nothing irregular could be perceived either in the ears themselves or in the throat. Leeches were applied behind the ears, and emetics and purgatives given; but no relief followed. Supposing that the symptoms might be dependent upon some anomalous state of the nervous apparatus, a blister was applied behind each ear, and the excoriated surface was sprinkled with half a grain of sulphate of morphia. By the next day the noise and deafness on the left side had quite ceased, and on the right were much abated:—the headache, too, had disappeared.

As the unpleasant feelings still continued on the right side, a second blister was applied and treated in the same manner as before, with morphia:—the success was decided, and the patient was quite freed of all his annoyances.

[We opine the blistering had quite as much to do with the cure as the morphia.]

23. *Typhus Fever in an Old Woman.*—M. Rayer exhibited to the Academy of

Medicine of Paris, August 30, a preparation of the morbid degeneration to which the glands of the small intestines are subject in typhus fever, as it occurs in Paris; and he prefaced the remarks on his case by saying, that some years ago, M. Chomel had declared, that he was not aware of a single authentic case of typhus fever having been met with in a person above the age of fifty-five. Since that period, M. Prus had reported an instance of a person seventy-four years of age, who was affected with that disease; and the individual from whom he obtained the specimens at present on the table, was fifty years of age when attacked.—*Lond. & Ed. Month. Journ.*, Oct. 1842.

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24. *Aphthæ of the Neck of the Uterus.*—M. Coute asserts, in a memoir read to the Academy of Sciences, 19th Sept. last, that aphthæ of the neck of the uterus, though not described by writers, is a very frequent affection.

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25. *On Percussion.*—By John Hughes Bennett. Mediate percussion as employed by M. Piorry, is undoubtedly a more valuable means of diagnosis than is generally allowed. His experience, it is said, enables him to "map out, as it were, on the surface of the skin, with ink, the size and form of the heart, arch of the aorta, liver, spleen, kidney, &c.; and indicate to the eighth of an inch, the exact height of pleuritic effusion, or the margin of circumscribed pneumonic dulness." At first sight this partakes too much of the marvellous, but when we know the length of time he takes to percuss a single patient, (half an hour,) we may suppose him to be a more expert operator than the generality of practitioners. The instruments he uses are, 1st. *The Hammer:* the head of which is made of steel, brass, or iron; a capsule is screwed to the end with a projecting disc of caoutchouc; the handle is made of wood, with depressions for the fingers and thumb. The head of the handle is not placed exactly at right angles with the handle, but has a slight obliquity upwards. "This is necessary, because in employing it the handle is almost certain to be somewhat elevated, and this slight obliquity even then allows the practitioner to strike the pleximeter perpendicularly." 2d. *The Pleximeter:* made of ivory, wood, or metal, with a handle at each extremity, to enable the practitioner to take hold of it more readily.

General rules to be followed in the practice of Mediate Percussion.—1. The pleximeter should be held by the projecting handles between the thumb and index finger of the left hand, and pressed firmly down upon the organ to be percussed. Much depends upon this rule being followed, as the sound and sense of resistence are considerably modified according to the pressure made by the pleximeter. A very easy experiment will prove this. If, for instance, the pleximeter be struck while it rests lightly on the abdomen over the umbilicus, and again, when it is pressed firmly down amongst the viscera, the change in tone will be at once perceived. In the first case a sound is produced, from the muscles and teguments being alone influenced by the force of the blow; in the second case, a clear tympanitic sound is occasioned from the vibration of the walls of the intestine. In every instance, therefore, the pleximeter should be so held and presssed down, as to render it, so to speak, a part of the organ we wish to percuss.

2. Care must be taken to strike the pleximeter fairly and perpendicularly. Unless this be done, vibrations are communicated to textures in the neighbourhood of the organ to be percussed, and fallacious results are the consequence. If, in percussing the lungs, for example, the blow be made obliquely, we obtain the dull sound produced by the rib, and I have seen considerable error in the diagnosis thus occasioned.

3. A strong or gentle stroke with the hammer will modify the tone and sense of resistance, inasmuch as the impulse may be communicated by one or the other to a deep-seated or a superficial organ. Thus a gentle stroke will elicit a pulmonal tympanitic sound just below the fourth rib, where a thin layer of lung covers the liver, but a strong one will cause a jecoral parenchymatous sound. At the inferior margin of the liver, on the other hand, where a thin layer of the

organ covers the intestines, the reverse of this takes place, a gentle stroke occasioning a dull, and a strong one a clear sound.

4. By withdrawing the hammer immediately after the blow, we are better able to judge of the sound; by allowing it to remain a moment, we can judge better of the sense of resistance.

5. The integuments should not be stretched over the part percussed, as when the stethoscope is employed, for an unnatural degree of resistance is thus communicated to the hand of the operator from the muscular tension. In every case, especially where the abdomen is examined, the integuments and superficial muscles should be rendered as flaccid as possible.

6. It is always best to percuss on the naked skin. It is not absolutely essential, however, and in cases where, from motives of delicacy, it is desirable that the chest or abdomen be not exposed, it only becomes necessary that the covering of linen or flannel be of equal thickness throughout, and not thrown into folds.

Special rules to be followed in percussing the chest.—Percussion of the lungs generally bears reference to a change in density, which is only to be detected by comparing the healthy with the morbid portions. The great practical rule here to be followed, is to apply the pleximeter to both sides of the chest in succession, with the same firmness, exactly in the same situation, and let the blow with the hammer be given with the same force. Care must be taken that the position of both arms be alike, as the contraction of the pectoral muscles on one side more than on the other may induce error. In short, every circumstance must be the same before it is possible to determine in delicate cases, either from the tone or sense of resistance, whether change of density exist in the lungs. When circumscribed alterations are discovered in the pulmonary tissue, their limits may be marked out on the surface of the skin, in the manner previously indicated. In this way, I have frequently succeeded in determining with accuracy the size and form of circumscribed indurations, arising from partial pneumonia and pulmonary apoplexy. Under the clavicles, the pleximeter must be applied with great firmness. Inferiorly, a thin layer of lung lies over the superior surface of the liver; and to determine the exact place where its inferior border terminates, the blows with the hammer should be very slight. Posteriorly, also, the pleximeter must be firmly applied, and the force of the blows considerable: but they should decrease in force inferiorly, where a thin layer of lung descends over the liver much deeper than anteriorly.

In a healthy state, a distinct difference may be observed in the sonoriety of the lungs immediately after a full expiration and a full inspiration. This does not take place when the tissue becomes indurated from any cause; and thus we are furnished with a valuable diagnostic sign. Congestion of the lung, and pneumonia in its first stage, causes only slight dulness and increased resistance, which, however, are readily detected by the practised percussor. In the second and third stage of pneumonia, and in apoplexy of the lung, this dulness and resistance are well marked, and even an impression of hardness and solidity communicated to the hand. When, however, the lung is studded with tubercles, the induration is most intense, and the greatest degree of resistance communicated.

Partial induration from pneumonia, apoplexy, or tubercular deposition, may be detected by percussion, even when deep-seated and covered by healthy portions of the lungs. In this case, by pressing with the pleximeter, and striking lightly, a tympanitic sound is only heard; but by pressing the pleximeter down firmly, and striking with force, the dull sound may be elicited and circumscribed. When induration, however, exists inferiorly in those portions of the lungs which overlap the liver, it requires great practice to detect them with certainty. Caverns in the lungs, when large and filled with air, induce a tympanitic sound; but they are generally more or less full of viscous and fluid matters, and give rise to dulness.

Two or three ounces of fluid may be detected in the pleural cavity, by causing the patient to sit up. It is readily distinguished posteriorly, from the dulness of the liver on the right side; on the left, however, the limit between it and the spleen is not so well marked. The height or level of the fluid is readily determined, and should be marked daily by a line made with nitrate of silver. If the effusion be only on one side, the peculiar humoral dulness is more easily detected. It disappears on placing the patient in such a position as will cause the fluid to accumulate in another part of the pleural cavity, when the space, which was previously dull, becomes clear. When the effusion entirely fills the pleural cavity, no limit of course can by detected; but, even then, the dulness is distinguished from that of the liver by the diminished feeling of resistance.

When air is effused into the pleura, the sound is like that of a drum, and readily detected.—*Braithwaite's Retrospect* from *Lond. & Edin. Monthly Journ. of Med. Sci.* Feb. 1842.

SURGERY.

26. *Injury to the Elbow-joint in Children.*—Mr. **Sylvester** communicated to the Reading Pathological Society a brief sketch of four cases of injury to the elbow-joint, occurring in children generally under four years of age, of relaxed and strumous habits, resulting, he thought, from partial dislocation of the radius, and caused by lifting the child by the wrists, or catching it by the arms when falling. The displacement was easily reduced, and as easily recurred.—Dr. Cowan's *Retrospective Address in Prov. Med. Journ.*, 13 Aug. 1842.

Sprains and partial dislocation of the shoulder and elbow-joints from careless handling of children are not of very rare occurrence. We have seen several examples of these accidents. Fractures of the forearm occur from the same causes. We were called to a child some years since, whose radius was fractured by her mother in helping her over a gutter.

27. *Operation for enlarged Patellar Bursa.*—Dr. **Hargrave** of Dublin, performed the following operation on a healthy housemaid, 21 years of age, admitted into the city of Dublin Hospital, with enlarged patellar bursa.

June 8th, 1841.—"An incision to the extent of one-eighth of an inch, was made along the outer margin of the tumour; then a very small bistoury was introduced obliquely into the cyst, at such a distance from the superficial cutaneous incision as prevented the escape of the fluid.

"The sac was then cut in several places, chiefly on the anterior surface, and the instrument withdrawn, all the fluid having been evacuated.

"A small compress was then applied, and several straps of adhesive plaster, and a roller which extended from the toes to the knee.

"A splint was also applied, which extended from the middle of the back part of the thigh to the same point of the leg.

"10th. Dressings were removed; considerable diminution in size of swelling.

"Straps of adhesive plaster were again applied nearly in the same way as that recommended by Baynton.—No constitutional disturbance.

"14th. Straps quite loose. A strong evidence of subsidence of swelling.

"17th. Natural appearance of the joint nearly restored.

"Discharged at her own request, but strictly cautioned against returning to her usual employment for some time.

"If the incision, or rather puncture into the sac," Dr. Hargrave says, "be made with care, the internal surface of the cyst then cautiously scored after it, the fluid evacuated by firm pressure, so as to prevent the ingress of air into the cavity, no danger need be apprehended of unpleasant effects succeeding to this measure." "The only instances," he adds, "in which the subcutaneous incision might fail, are those where the sac is much thickened, its interior loculated, and the cells filled with a thick gelatiniform substance: still in such instances, it is a means which should be kept in view."—*Dublin Med. Press*, Oct. 26, 1842.